State: Arkansas Filing Company: USAble Life

TOI/Sub-TOI: H14I Individual Health - Hospital Indemnity/H14I.000 Health - Hospital Indemnity

Product Name: Hospital Indemnity Applications, HIP2 & HIP2-R - R

Project Name/Number: Hospital Indemnity Applications, IHIP, HIP2 & HIP2-R/AR001930100004

Filing at a Glance

Company: USAble Life

Product Name: Hospital Indemnity Applications, HIP2 & HIP2-R - R

State: Arkansas

TOI: H14I Individual Health - Hospital Indemnity

Sub-TOI: H14I.000 Health - Hospital Indemnity

Filing Type: Form

Date Submitted: 01/16/2013

SERFF Tr Num: LSVX-G128852614 SERFF Status: Closed-Approved

State Tr Num:

State Status: Approved-Closed
Co Tr Num: AR001930100004

Implementation 01/16/2013

Date Requested:

Author(s): SPI Life and Specialty Ventures

Reviewer(s): Donna Lambert (primary)

Disposition Date: 01/17/2013
Disposition Status: Approved

Implementation Date:

State Filing Description:

SERFF Tracking #: LSVX-G128852614 State Tracking #:

Company Tracking #: AR001930100004

State: Arkansas Filing Company: USAble Life

TOI/Sub-TOI: H14I Individual Health - Hospital Indemnity/H14I.000 Health - Hospital Indemnity

Product Name: Hospital Indemnity Applications, HIP2 & HIP2-R - R

Project Name/Number: Hospital Indemnity Applications, IHIP, HIP2 & HIP2-R/AR001930100004

General Information

Project Name: Hospital Indemnity Applications, IHIP, HIP2 & Status of Filing in Domicile:

HIP2-R

Project Number: AR001930100004 Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments:
Explanation for Combination/Other: Market Type: Individual
Submission Type: New Submission Individual Market Type:

Overall Rate Impact: Filing Status Changed: 01/17/2013

State Status Changed: 01/17/2013

Deemer Date: Created By: SPI Life and Specialty Ventures

Submitted By: SPI Life and Specialty Ventures Corresponding Filing Tracking Number:

Filing Description:

We are filing, for your review and approval, revised Hospital Confinement Indemnity applications. They have been revised pursuant to the MIB requirement to change the MIB authorization to comply with final HIPAA Regulations.

HIP2-APP (1-13) and HIP2-HSA-APP (1-13) will replace the previously approved HIP2-APP (8-07) and HIP2-HSA-APP (8-07), which were approved on 8/17/2007 under SERFF Filing ID LSVX-125262640 (AR Filing ID 36663). They can be used with our Hospital Confinement Indemnity Policy, HIP2 (3-07), which was approved on 3/19/2007 under SERFF Filing ID LSVX-125118855 (AR Filing ID 35256).

HIP2-RAPP (1-13) will replace the previously approved HIP2-RAPP (6-11), which was approved on 12/15/2011 under SERFF Filing ID LSVX-G127900447 (AR Filing ID 50489). It can be used with our Hospital Confinement Indemnity Policy, HIP2-R (3-07), which was approved on 10/20/2011 under SERFF Filing ID LSVX-G127566147 (AR Filing ID 49795).

We made the following revision to these applications: In the authorization section, added the phrase "(c) authorize USAble Life or its reinsurer to make a brief report of my personal health information to MIB."

The following form was previously approved by your department and will be also be used with these forms:

APP-NOTICE (9-08) - Application Notice - 10/23/2008

These applications may, at some time in the future, be converted to electronic documents. Such adaptation may slightly alter the appearance of these documents, but we assure that their content will not change and their readability compliance will not be affected.

Company and Contact

Filing Contact Information

Rob Wittenburg, Legal Product Specialist rwittenburg@usablelife.com

PO Box 1650 501-212-8877 [Phone] 8877 [Ext]

Little Rock, AR 72203-1650 501-235-8484 [FAX]

SERFF Tracking #: LSVX-G128852614 State Tracking #:

Company Tracking #: AR001930100004

State ID Number:

State: Arkansas Filing Company: USAble Life

TOI/Sub-TOI: H14I Individual Health - Hospital Indemnity/H14I.000 Health - Hospital Indemnity

Product Name: Hospital Indemnity Applications, HIP2 & HIP2-R - R

Project Name/Number: Hospital Indemnity Applications, IHIP, HIP2 & HIP2-R/AR001930100004

Filing Company Information

USAble Life CoCode: 94358 State of Domicile: Arkansas
PO Box 1650 Group Code: 876 Company Type: Life & Healh

Little Rock, AR 72203-1650 Group Name: Life and Speciality

\$150.00

(501) 375-7200 ext. [Phone] Ventures (LSV)

FEIN Number: 71-0505232

Filing Fees

Fee Amount:

Fee Required? Yes

Retaliatory? No

Fee Explanation:

Per Company: No

Company	Amount	Date Processed	Transaction #
USAble Life	\$150.00	01/16/2013	66604248

State: Arkansas Filing Company: USAble Life

TOI/Sub-TOI: H14I Individual Health - Hospital Indemnity/H14I.000 Health - Hospital Indemnity

Product Name: Hospital Indemnity Applications, HIP2 & HIP2-R - R

Project Name/Number: Hospital Indemnity Applications, IHIP, HIP2 & HIP2-R/AR001930100004

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	01/17/2013	01/17/2013

State: Arkansas Filing Company: USAble Life

TOI/Sub-TOI: H14I Individual Health - Hospital Indemnity/H14I.000 Health - Hospital Indemnity

Product Name: Hospital Indemnity Applications, HIP2 & HIP2-R - R

Project Name/Number: Hospital Indemnity Applications, IHIP, HIP2 & HIP2-R/AR001930100004

Disposition

Disposition Date: 01/17/2013

Implementation Date: Status: Approved

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Health - Actuarial Justification	Approved	Yes
Supporting Document	Outline of Coverage	Approved	Yes
Supporting Document	Statement of Variability	Approved	Yes
Form	Hospital Confinement Policy Application & Change Form	Approved	Yes
Form	Hospital Confinement Policy Application & Change Form	Approved	Yes
Form	Hospital Confinement Policy Application & Change Form	Approved	Yes

State: Arkansas Filing Company: USAble Life

TOI/Sub-TOI: H14I Individual Health - Hospital Indemnity/H14I.000 Health - Hospital Indemnity

Product Name: Hospital Indemnity Applications, HIP2 & HIP2-R - R

Project Name/Number: Hospital Indemnity Applications, IHIP, HIP2 & HIP2-R/AR001930100004

Form Schedule

Lead	Form Number: HII	P2-APP (1-13)							
Item	Schedule Item	Form	Form Form Action Specific Readabilit			Readability			
No.	Status	Name	Number	Туре	Action	Data		Score	Attachments
1	Approved 01/17/2013	Hospital Confinement Policy Application &	HIP2-APP (1-13)	AEF	Revised	Previous Filing Number:	36663	47.700	HIP2-APP (1- 13).PDF
		Change Form				Replaced Form H Number:			Í
2	Approved 01/17/2013	Hospital Confinement Policy Application &	HIP2-HSA- APP (1-13)		Revised	Previous Filing Number:	36663	47.700	HIP2-HSA-APP (1- 13).PDF
		Change Form	, , ,			Replaced Form Number:	HIP2-HSA-APP (8-07)		,
3	Approved 01/17/2013	Hospital Confinement Policy Application &	HIP2-RAPP (1-13)	AEF	Revised	Previous Filing Number:	50489	47.700	HIP2-RAPP (1- 13).PDF
		Change Form				Replaced Form Number:	HIP2-RAPP (6- 11)		

Form Type Legend:

roilli i y	pe Legena.		
ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
отн	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages



HOSPITAL CONFINEMENT POLICY

Office Use Only				
Effective Date				
Policy Number				
Group Number				
Dept./Loc.				

P.O. Box 1650 Little Rock, Arkans	as 72203 APPLIC	,A I	ION	& Cr	1ANC		ORIVI		ot./Loc.	+	
☐ New Application	☐ Change Form	Пг	eplaces P	olicy No.				DO	J., 200.		
	SONAL IDENTIFICATION			00) 1.101 _			_				
Name (First, MI, Last)			F	or Name	Change, G	Sive Pric	or Last Name	Э	Social Secu	rity #	
Home Address			City			State	Zip		County		
Name of Employer			Date Em	nployed Fu	ıll-Time	Occup	pation		Height (ft-in) Wei	ght (lbs.)
Date of Birth	Birth State or Country		Sex		Work P	hone			Home Phon	ie	
SPOUSE & CHILD	 DREN INFORMATION - (Comi	olete if	Applyin	a for De	pende	ent's Cov	erage			
	posed for Insurance	<u> </u>	Date of l		Birth S		Marital	<u> </u>		Height	Weight
	middle, last name	mo	o. day	yr.	or Cou		Status	Age	Sex	(ft-in)	(lbs.)
(spouse)											
(child)											
(child)											1
(child)											
(child)											
SECTION 2 - PLA	N SELECTION			New App	licant		■ App	olication	for Change		
CHECK COVERAGE I				•			• •		<u> </u>		
☐ Applicant	Applicant & Spou	se		Applican	t & Childre	n		pplicant,	Spouse & Chi	ldren	
and Specified Plan II - \$100 D	ily Hospital Confinement, \$100 d Injury. Daily Hospital Confinement, \$25	50 Em	ergency A	ccident, \$	\$1,500 Sur	•					
☐ Plan III - \$200 I	mbulance Ground/Air, \$75 Wel Daily Hospital Confinement, \$5 Ground/Air, \$75 Wellness, and	00 Em	nergency <i>i</i>	Accident,		rgery &	Anesthesia	, \$75 Out	patient Sickne	:ss, \$500/\$^	1,000
Add Delete	Optional Rider(s):	Specii	ieu irijui y	•			Δι	mount			
	Annual Hospital Admission R	ider				□ \$!	500	\$750	\$1,000	1	
	Hospital Intensive Care Confi		nt Rider			_	200	\$400	\$600		
	Heart Attack, Stroke, Coma &			ofit Rider			1,000/\$500	_	\$2,000/\$1,00		
	Trout Fittack, Stroke, Soma a	i ara	lysis bene	ant reider		_	otal Mont	_		o .	
1. Is this ins	surance to replace or chai	nge c	ther ins	urance?	' <u></u>				give details		
	name of company.										
If "No", lis	st all other Hospital Indem	nnity	policies	and the	ir daily b	enefit(s).				
0 11-				(1	-1 1		2111	- \0 [NI. /.l	.1
	received the Outline of (」Yes □	No (chec	
that I have read and un to make a brief report of facility, insurance or rei application) regarding of give to USAble Life, its except MIB, to give suc	epresent that the statements and derstand the "Important Note and of my personal health information neurone company, or MIB has bur mental and physical health, as reinsurers, or its legal represent records or knowledge to any that this authorization shall be varied.	nd the on to ving in other i entative agenc	Insurance MIB; (d) a formation nsurance e any and ay employe	e Fraud Wouthorize a on me or coverage, I all such ed by the o	arning" on any physici any memb hazardou informatior company to	page 2 an, med per of my s activition to use o collect	of this application of this application of the distribution of the	cation; (c) oner, hos ly those v er, genera riting insu it such in	authorize US, pital, clinic, or vho have appli al reputation, fin urance; (e) aut formation in or	Able Life or other medial of covernances, and horize all sarder to facilit	its reinsurer cally related grage on this d vocation to aid sources, tate its rapid
	and Lundarstand that a conv										non snan DC

as valid as the original and I understand that a copy is available to me or my representative upon request; (h) acknowledge receipt of written notification describing the use of the (MIB) as required by the Fair Credit Reporting Act; and (i) acknowledge receipt of the Information Practices Notice and the Insurance Fraud Warning. I have read and understand the above statements and agreements. In applying for insurance, I authorize my employer to make the necessary payroll deductions to pay for my insurance. I understand failure to disclose a proposed insured person's true health condition may void the policy.

	Be sure to complet	e the B	eneficiary & Medic	cal Information on page 2/reve	rse side.
Signed at:			Date of Application		Date Received Home Office
_	(City and State)		•	(Month, Day, Year)	
X		X			
	Agent's Signature	_		Applicant's Signature	
HIP2-APP (1-13)			Page 1 of 2	2	

Em	nployee's Name (Last, First, M.I.)	Social Security #	Employer Name	Employer Name		
SE	ECTION 3 – BENEFICIARY	■ Name B	eneficiary ■ Ch	nange of Beneficiary			
	I hereby revoke the appointr	ment of any existing benef	ficiary and designate t	he following beneficiary unde	r this po	olicy.	
	Name	Birthdate	Relationship	Primary or Secondary	Indic Percei		
		☐ Primary or ☐ Secondary					
				☐ Primary or ☐ Secondary			
SE	ECTION 4 – MEDICAL INFO	RMATION					
1.	recommended by a physicia		and details:	e, or has hospitalization beer	Ш	No	
2.	because of internal cancer disease, hypertension, c emphysema, sickle-cell and rheumatoid arthritis?	, melanoma, heart surge hronic obstructive pulm	ery, heart attack, cong nonary disease, chr onchitis, Parkinson's o	ne within the last 12 months gestive heart failure, vascula onic liver disease, stroke disease, multiple sclerosis, o	r , 🔲 r		
3.	Alzheimer's disease, senile Acquired Immune Deficie Immunodeficiency Virus (H	e dementia, systemic lupu ency Syndrome (AIDS)	us, kidney failure, dial , AIDS Related C	of the medical profession for petes, alcohol or drug abuse omplex (ARC), or Humar	, 🖂		
4.	Is anyone to be covered no Person(s):	w pregnant?	Details:				
5.		Yes No If "Yes," Person(s):	list person(s), medica	r of the medical profession for ations taken, medication dosa	ge and		
	The person(s) named above o be signed by the applican			from coverage by an Exclus	sion rid	er	
6.	PRIMARY PHYSICIAN'S N	AME:	A	ddress:			
	Phone	Number:	City, Sta				

IMPORTANT NOTE: The entire contract will consist of this application and the insurance issued in response to it. THE INSURANCE WILL NOT BE EFFECTIVE ON THE PROPOSED INSURED UNLESS: (1) The policy is delivered to the Owner; (2) The first modal premium is paid; (3) There has been no change since the date of this application and the effective date of the policy in the health of the Proposed Insured as stated in this application; and (4) To satisfy premium deduction requirements of my employer and dating requirements of our Section 125 Plan, if applicable, I understand that my policy will be dated and become effective on the first day of the month following the Section 125 Plan effective date (anniversary date for resolicitation) or on the first day of the month following underwriting approval, whichever is later. There is no coverage until the effective date of the policy.

Insurance Fraud Warning - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines and confinement in prison.



HOSPITAL CONFINEMENT POLICY APPLICATION & CHANGE FORM

Office	Use Only
Effective Date	
Policy Number	
Group Number	
Dept./Loc.	

P.O. Box 1650 APPLICATION & CHANGE FORM Little Rock, Arkansas 72203

☐ New Application	☐ Change Form	•	s Policy No								
	SONAL IDENTIFICATIO	N	Far Name (Channa C	Since Daile	n Loot Nove		Casial Cas			
Name (First, MI, Last)			For Name (∍nange, €	oive Prio	r Last Nam	е	Social Sec	urity #		
Home Address		City	1		State	Zip		County	County		
Name of Employer	Employed Fu	II-Time	Occup	oation		Height (ft-in	n) We	eight (lbs.)			
Date of Birth	Birth State or Country	Sex		Work F	hone			Home Pho	ne		
SPOUSE & CHILD	REN INFORMATION - C	Complete	if Applying	for De	pende	ent's Cov	erage				
Person Propo	osed for Insurance		of birth	Birth S	State	Marital			Height	Weight	
	middle, last name	mo. d	lay yr.	or Cou	ıntry	Status	Age	Sex	(ft-in)	(lbs.)	
(spouse)											
(child)											
(child)											
(child)											
(child)											
SECTION 2 – PLAI			New Appl	icant		■ Ap	plication	for Change	9		
CHECK COVERAGE D			_ , , ,	0.01.11.1				0 00			
Applicant	Applicant & Spous	se	Applicant	& Childre	n		Applicant,	Spouse & Ch	ııldren		
Hospital Confinem	` '	_	A '				4000 II				
-	y Hospital Confinement, \$100	0 3			•			•			
	aily Hospital Confinement, \$25 aily Hospital Confinement, \$50	•	•					•			
	ally nospital Collinement, \$50	Ju Emergeni	cy Accident, \$	1,000 AH	iluai no	Spital Autili	55IUII, \$0	uu nuspitai iii	terisive Ca	16.	
					To	otal Mont	hly Pre	mium: \$_			
1 Is this insu	urance to replace or char	nge other i	nsurance?	П		_		give details			
	name of company.	.90 0					, ,	g. 1 0			
If "No", list	t all other Hospital Indem	nity policie	es and their	daily b	enefit(s	s).					
	·				,						
2. Have you	received the Outline of C	Coverage (in those sta	ates whe	ere red	uired by	law)? [☐ Yes ☐	No (che	ck one)	
•	epresent that the statements an		·						`	,	
	derstand the "Important Note an										
to make a brief report of	f my personal health information	on to MIB; (d	d) authorize a	ny physici	ian, med	dical practiti	oner, hos	pital, clinic, or	other med	dically related	
	nsurance company, or MIB hav										
	ur mental and physical health, or reinsurers, or its legal represe										
	records or knowledge to any a										
	at this authorization shall be va										
	and I understand that a copy										
	e (MIB) as required by the Fair (
	e read and understand the ab										
necessary payroll deduc	tions to pay for my insurance.	i understand	rallure to disc	iose a pro	posea II	nsurea pers	son's true	nealth condition	on may voic	i the policy.	
E	Be sure to complete the	Benefici	ary & Medi	ical Info	ormatio	on on pa	ge 2/re	verse side.			
Signed at:	(City and State)	Date o	f Application	·	/8.4	onth, Day, Year	A	Date Re	eceived Ho	me Office	
					(IVIC	יינוו, טay, Yeal	,				
XAgen	t's Signature	х		Applicant	's Signatur	e					
HIP2-HSA-APP (1-13)			Page 1 of	2	-						

Em	ployee's Name	(Last, First, M.I.)		Social Security #	Employer Name			
SE	CTION 3 – B	ENEFICIARY	■ Name Bei	neficiary Ch	nange of Beneficia	ary		
	I hereby revo	ke the appointment of an	y existing benefic	iary and designate t	he following ben	eficiary und	er this po	licy.
		Name	Birthdate	Relationship	Primary or Se	econdary Indic		
					☐ Primary or ☐	Secondary		
					☐ Primary or ☐	Secondary		
SE	CTION 4 – M	EDICAL INFORMATION	N					
1.	•	be covered currently covered by a physician? If "Yes	s," list person(s) a	nd details:	e, or has hospita	lization bee	n Yes	No
		-						
2.	because of disease, hy	e to be covered been continued internal cancer, melanon expertension, chronic of a sickle-cell anemia, asther thritis?	na, heart surgery ostructive pulmo nma, chronic bron	y, heart attack, cond nary disease, chr achitis, Parkinson's d	gestive heart fail onic liver dise	ure, vascula ase, stroke	ar e, 🔲	
3.	Alzheimer's Acquired Ir	to be covered ever beer disease, senile dementia mmune Deficiency Syr ciency Virus (HIV)?	a, systemic lupus ndrome (AIDS),	, kidney failure, dial AIDS Related C	betes, alcohol or	drug abuse or Huma	e, n 🗆	
4.	Is anyone to	be covered now pregnar	nt?					
	Person(s):	1 3		Details:				_
	Has anyone (high blood presson Medication,	to be covered ever bee pressure)?	No If "Yes," li Dates:	st person(s), medica	ations taken, med	dication dos	age and	last two
) named above in quest by the applicant prior to			from coverage k	y an Exclu	sion ride	er
6.	PRIMARY P	PHYSICIAN'S NAME:		A	ddress:			
		Phone Number:		City, Sta	ate, Zip:			

IMPORTANT NOTE: The entire contract will consist of this application and the insurance issued in response to it. THE INSURANCE WILL NOT BE EFFECTIVE ON THE PROPOSED INSURED UNLESS: (1) The policy is delivered to the Owner; (2) The first modal premium is paid; (3) There has been no change since the date of this application and the effective date of the policy in the health of the Proposed Insured as stated in this application; and (4) To satisfy premium deduction requirements of my employer and dating requirements of our Section 125 Plan, if applicable, I understand that my policy will be dated and become effective on the first day of the month following the Section 125 Plan effective date (anniversary date for resolicitation) or on the first day of the month following underwriting approval, whichever is later. There is no coverage until the effective date of the policy.

Insurance Fraud Warning - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines and confinement in prison.



P.O. Box 1650 Little Rock, Arkansas 72203

HOSPITAL CONFINEMENT POLICY APPLICATION & CHANGE FORM

Office Use Only					
Effective Date					
Policy Number					
Group Number					
Dept./Loc.					

	☐ Change Form	n \square R	einstateme	ent Policy		Repl	laces Po	licy No.	·		
SECTION 1 – PERSO	ONAL IDENTIFICATION	V									
Name (First, MI, Last)			For Nam	e Change, (Give Pric	or Last	Name		Social S	ecurity No).
Home Address		City			State		Zip		County		
Date of Birth	Birth State or Country	1	Gender	☐ Male ☐ Fema	le		Height (ft-in)		Weigh	t (lbs.)
Occupation	,	Applicant's ema	ail address	(if any)			Home P	hone		Other I	Phone)
Name of Employer				Type of Bu	ısiness	•					
1. Are you a US citizen	? Yes No	2. If no	to question	n 1, have yo	u been i	issued	a perma	anent re	esidency	VISA?	Yes No
3. If yes to question 2,	have you lived continuous	sly in the US or C	anada for t	the last 6 mo	onths?	☐ Y	es 🔲 I	No			
SPOUSE [& CHILDR	en] information - (Complete if Ap	plying fo	r Depende							
Fı	ıll Name	Occup	nation	Gender	Da mo	te of B day	Sirth yr		State ountry	Height ft /in	Weight Ibs
(spouse)	iii rvame	Occup	Jation	Gender	1110	uay	l yı	0. 0		10,111	
[child]											
[child]											
[child]											
SECTION 2 – PLAN	SELECTION	☐ New	Applicar	nt	A	pplica	ation fo	r Char	nge		
	SELECTION ESIRED: Applicant	New Applicant &			Ant & Ch					e & Childre	en]
	ESIRED: Applicant										en]
CHECK COVERAGE D Hospital Confinem Plan I - \$50 Dail	ESIRED: Applicant	Applicant &	Spouse	[Applica	ant & Ch	ildren	☐ Ap				
CHECK COVERAGE D Hospital Confinem Plan I - \$50 Dail \$250/\$500 Ar Plan II - \$100 D	ESIRED: Applicant nent Plan(s): y Hospital Confinement, \$	Applicant & S100 Emergency Specified Injury.	Spouse Accident, \$	[Applica \$1,000 Surg , \$1,500 Surg	ery & Ar	ildren nesthe	☐ Ap				
CHECK COVERAGE D Hospital Confinem Plan I - \$50 Dail \$250/\$500 Ar Plan II - \$100 D \$75 Outpatier Plan III - \$200 D	ESIRED: Applicant nent Plan(s): ly Hospital Confinement, \$ nbulance Ground/Air, and aily Hospital Confinement	Applicant & S100 Emergency Specified Injury. , \$250 Emergency Inbulance Grouncy Specified Specified Injury.	Accident, \$ cy Accident d/Air, and S cy Acciden	[Applica \$1,000 Surg , \$1,500 Surg Specified Inju t, \$2,500 Su	ery & Arrgery & Arury.	ildren nesthe: Anesth	□ Ap sia, nesia,				
CHECK COVERAGE D Hospital Confinem Plan I - \$50 Dail \$250/\$500 Ar Plan II - \$100 D \$75 Outpatier Plan III - \$200 D \$75 Outpatier	ESIRED: Applicant nent Plan(s): y Hospital Confinement, \$ nbulance Ground/Air, and aily Hospital Confinement th Sickness, \$250/\$500 Ar Daily Hospital Confinement	Applicant & S100 Emergency Specified Injury. , \$250 Emergency anbulance Ground the S500 Emergency Ambulance Ground Ambulance Ground the S500 Emergency Ambulance Ground the S5	Accident, \$ cy Accident d/Air, and S cy Acciden	[Applica \$1,000 Surg , \$1,500 Surg Specified Inju t, \$2,500 Su	ery & Arrgery & Arrgery & Arry. Irgery & Arry. Irgery & Arry.	ildren nesthe: Anesth	Apsia, nesia, hesia,			Pi	
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App	licant's Name (Last, First, M.I.)	Social Security No).	
ÇE	CTION 4 – MEDICAL INFORMATION			
1.	Is anyone to be covered currently confined in a hospital or nursing home, or has hospit	alization boon recommended by a	Yes	No
1.	physician?	alization been recommended by a		
2.	2. Has anyone to be covered been confined in a hospital or nursing home within the last 12 months because of internal cancer, melanoma, heart surgery, heart attack, congestive heart failure, vascular disease, hypertension, chronic obstructive pulmonary disease, chronic liver disease, stroke, emphysema, sickle-cell anemia, asthma, chronic bronchitis, Parkinson's disease, multiple sclerosis, or rheumatoid arthritis?			
3.	Has anyone to be covered ever been diagnosed or treated by a member of the medical p senile dementia, systemic lupus, kidney failure, diabetes, alcohol or drug abuse, Acqui (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV)?	rofession for: Alzheimer's disease, red Immune Deficiency Syndrome		
4.	Is anyone to be covered currently pregnant? Yes No Has anyone to be covered	ever had a problem pregnancy?		
5.	Has anyone to be covered ever been diagnosed or treated by a member of the medical prof pressure)?	ession for hypertension (high blood		
	If "Yes," list person(s), medications taken, medication dosage and last two blood pressure re	eadings.		
	Medication, Dosage, Readings with Dates:			
	he person(s) named above in questions 1 through 5 may be excluded from coverage b rior to policy issuance.	y an Exclusion rider to be signed b	y tne a	pplicant
6.	Name, address and phone number of the personal physician(s):			
	Give details for "yes" answers to any questions and indicate to	whom answers relate.		

Αp	oplicant's Name (Last, First, M.I.)	Social Security No.
SE	ECTION 5 – AUTHORIZATION	
1.	Does any person applying for coverage currently have a Hospital Indemnity If yes, give name of company, list type of policy and amount of coverage	Policy with us or any other insurance company? Yes No
2.	REPLACEMENT: Is this insurance to replace or change other insurance?	Yes No If "Yes", give details including name of company.
3.	OUTLINE: Have you received the Outline of Coverage? Yes No	(check one)
	In signing below, I (a) represent that the statements and answers given on a best of my knowledge and belief; (b) state that I have read and understand the USAble Life or its reinsurer to make a brief report of my personal health information, or other medically related facility, insurance or reinsurance company, or of my family (only those who have applied for coverage on this application hazardous activities, character, general reputation, finances, and vocation to such information to use for underwriting insurance; (e) authorize all said source by the company to collect and transmit such information in order to facilitate it years from the application date; (g) agree that a photocopy of this authorization me or my representative upon request; (h) acknowledge receipt of written reby the Fair Credit Reporting Act and the Notice of Insurance Information Pract In applying for insurance, I authorize my employer to make the necessary paproposed insured person's true health condition may void this policy.	e "Important Note" and the "Insurance Fraud Warning" below; (c) authorize ormation to MIB; (d) authorize any physician, medical practitioner, hospital, Medical Information Bureau, Inc. having information on me or any member on) regarding our mental and physical health, other insurance coverage, give to USAble Life, its reinsurers, or its legal representative any and all es, except MIB, to give such records or knowledge to any agency employed is rapid submission; (f) agree that this authorization shall be valid for two (2) on shall be as valid as the original and I understand that a copy is available otification describing the use of the Medical Information Bureau as required tices. I have read and understand the above statements and agreements.
	IMPORTANT NOTE: The entire contract will consist of this application NOT BE EFFECTIVE ON THE PROPOSED INSURED UNLESS: (1) The There has been no change since the date of this application and the effective application; and (4) To satisfy premium deduction requirements of my emunderstand that my policy will be dated and become effective on the first date for resolicitation) or on the first day of the month following underwriting of the policy. [I understand and accept that the coverage I am purchasing dobirth or adoption as stated in the policy and that no dependent (child) will consent and approval of USAble Life.]	policy is delivered to the Owner; (2) The first modal premium is paid; (3) e date of the policy in the health of the Proposed Insured as stated in this ployer and dating requirements of our Section 125 Plan, if applicable, I by of the month following the Section 125 Plan effective date (anniversary approval, whichever is later. There is no coverage until the effective date as not include dependent (child) coverage except for the initial 90 days from
	Insurance Fraud Warning - Any person who knowingly presents a false of false information in an application for insurance is guilty of a crime and may	
	I have read and understand the above statements and agreements.	
	X	Signed at:
	Applicant's Signature	(City and State)
		Date of Application:
	Agent's Statement: I have truly and accurately recorded the information supplied by the applicant.	(Month, Day, Year)
	X	
	Agent's Signature	Agent's License ID Number
	Agent's Printed Name	-
		Date Received Home Office

State: Arkansas Filing Company: USAble Life

TOI/Sub-TOI: H14I Individual Health - Hospital Indemnity/H14I.000 Health - Hospital Indemnity

Product Name: Hospital Indemnity Applications, HIP2 & HIP2-R - R

Project Name/Number: Hospital Indemnity Applications, IHIP, HIP2 & HIP2-R/AR001930100004

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved	01/17/2013
Comments:			
Attachment(s):			
AR Readability Certificati	on.PDF		
		Item Status:	Status Date:
Bypassed - Item:	Application	Approved	01/17/2013
Bypass Reason:	Not a policy filing		
		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved	01/17/2013
Bypass Reason:	Not a rate filing		
		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved	01/17/2013
Bypass Reason:	Not a policy filing		
		Item Status:	Status Date:
Satisfied - Item:	Statement of Variability	Approved	01/17/2013
Comments:			
Attachment(s):			
HIP2-RAPP Statement of	f Variability.PDF		

STATE OF ARKANSAS

READABILITY CERTIFICATION

COMPANY NAME: USAble Life

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
HIP2-APP (1-13)	47.7
HIP2-HSA-APP (1-13)	47.7
HIP2-RAPP (1-13)	47.7

Signed:

Name: Sally A. Murphy

Senior Counsel, Chief Compliance Officer and

Title: Assistant Secretary

Date: 1/16/2013

STATEMENT OF VARIABILITY

Any use of variability shall be administered in a uniform and non-discriminatory manner and shall not result in unfair discrimination.

SPECIFIC VARIABLES HIP2-RAPP

Section 1 – Personal Identification

1. All language regarding dependent children can be removed if the policy does not provide coverage for dependent children.

Section 2 – Plan Selection

1. All language regarding dependent children can be removed if the policy does not provide coverage for dependent children.

Section 5 – Authorization

1. All language regarding dependent children can be removed if the policy does not provide coverage for dependent children.